

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 11/22/2011 | |
| NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint number IN00099634.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the (PSR) 10/7/11 to the Recertification and State Licensure Survey completed on 9/2/11.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint number IN00096674 and IN00098074 completed on 10/7/11.</p> <p>Complaint number IN00099634 unsubstantiated due to lack of evidence</p> <p>Survey date: November 22, 2011</p> <p>Facility number: 000316 Provider number: 155491 Aim number: 100286370</p> <p>Survey team: Leslie Parrett RN</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type: Medicare: 15 Medicaid: 67 Other: 31 Total: 113</p> <p>Sample: 4 Supplemental Sample: 2</p> | | | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | <p>Continued From page 1</p> <p>Lincoln Centers for Rehabilitation and Healthcare was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00099634.</p> <p>Quality review completed 11/28/11 Cathy Emswiller RN</p> | | | F 000 | | | |